Committee on Ways and Means

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Reimbursement for Part B Drugs: Average Wholesale Price Reform

Flawed System Overpays For Drugs, Underpays for Services

- For the approximately 450 drugs (primarily chemotherapies and antibiotics) that are currently covered by Medicare, providers are reimbursed at 95 percent of the Average Wholesale Price (AWP) of the drug.

- AWP is not defined by law or regulation. As manufacturers compete, there are incentives for manufacturers to raise the AWP for certain drugs, while reducing the acquisition cost for physicians through discounts and rebates. Manufacturers and physicians play this "spread" between acquisition cost and AWP, creating an upward spiral of overpayment for drugs and costs for Medicare.

- In 2001, according to the General Accounting Office (GAO) and Centers for Medicare and Medicaid Services (CMS), Medicare overpaid for Part B drugs by over $1 billion annually. In 2002, oncologists collected approximately $600 million in overpayments.

- The GAO, the Department of Health and Human Services' Office of Inspector General (OIG), and MedPAC have each identified that the present system for reimbursing Part B drugs is seriously flawed and inflationary. For example, MedPAC estimates spending increased almost 35 percent between 2001 and 2002. Spending for oncology therapies increased by 41 percent.

- Despite the nonpartisan research demonstrating overpayments, oncologists and certain other providers argue that the payments received through the physician fee schedule for the administration of these drugs does not fully reflect the true costs of providing drugs to seniors.

Overpayments "Tax" Patients

These overpayments 'tax" patients who must pay a 20 percent coinsurance on the inflated AWP of the drug. The OIG estimated that in 2000, Medicare beneficiaries paid $177 million in unnecessarily inflated co-payments for physician-administered drugs.

Conference Agreement Increases Fee Schedule Reimbursement For Oncologists

The physician fee schedule payments for oncologists and other specialists are increased significantly to accurately pay doctors for the cost of administering drugs. Specifically, the Agreement:

- Directs CMS to use the cancer community's own data to calculate practice expenses, as submitted by the American Society of Clinical Oncologists;
- Directs CMS to use the higher oncology nursing salaries from the ASCO survey data to calculate practice expenses for drug administration;
- Requires an examination of existing codes for drug administration and exempts any revisions from budget neutrality requirements;
- Allows for additional supplemental surveys on practice expenses for drug administration, and exempts any resulting changes from budget neutrality; and
- Requires MedPAC review of payment changes as they affect payment and access to care by January 2005 for oncologists, and by January 2006 for other affected specialties.

In addition, the Conference report provides significant resources in transition costs for oncologists and other affected specialties, such as hematologists.

Conference Agreement Increases Drug Reimbursement For Oncologists

The Conference Agreement provides:

- In 2004, reimbursement at AWP-15%.
- In 2005 and therafter, reimbursement at the Average Sales Price (ASP) plus 6%.
- In 2006 and beyond, physicians would annually select a reimbursement methodology for drugs, Average Sales Price (ASP) plus 6% or receive the drugs on a stock-replacement basis through a Medicare contractor.

Defined in law, the ASP represents an average for the final sales prices in the U.S., net of rebates, or other discounts. The ASP will be defined in law. The Secretary has the authority to adjust reimbursement for a drug, where the ASP is found to not reflect widely available market prices.

By comparison, in the House-passed bill, physicians would either be reimbursed at ASP + 0% or receive drugs on a stock-replacement basis through a Medicare contractor. For a two-year transition period, physicians would have been paid at ASP+12%.

If a physician chooses to receive the drugs through a Medicare contractor, then there would be no billing to the physician. Instead:

- Physicians would write a prescription to be filled by a Medicare-contracted supplier that would then dispense the product to the doctor on a timely basis. Medicare would guarantee the availability of at least two contractors available in each region and would set

standards for service and solvency, shipment and delivery, responses to physician inquiries.

- Physicians would deliver the prescribed drug necessary for the patient, when the patient is seen by the physician. The supplier, not the physician, would be reimbursed by Medicare. The supplier would be responsible for collection of the 20% co-insurance on the drug payment, lowering the bad debt exposure for physicians' practices.